

Diagnosis:_

Request for Prior Authorization Aripiprazole Tablets with Sensor (Abilify MyCite)

FAX Completed Form To 1 (800) 574-2515

Provider Help Desk 1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

	,				
IA Medicaid Member ID #	Patient name DOB				
Patient address					
Provider NPI	Prescriber name		Phone		
Prescriber address			Fax		
Pharmacy name	Address		Phone		
Prescriber must complete all informa	ition above. It must be legible, correct, and	l complete or fo	orm will be re	turned.	
Pharmacy NPI	Pharmacy fax	NDC			
Prior authorization (PA) is require considered under the following co	d for aripiprazole tablets with sensor (anditions:	Abilify MyCite	e). Payment	: will be	
1) Patient has a diagnosis of Sch	izophrenia, Bipolar I Disorder, or Majo	r Depressive	Disorder; a	nd	
2) Patient meets the FDA approved age for use of the Abilify MyCite device; and					
3) Dosing follows the FDA approved dose for the submitted diagnosis; and					
(prescriber must provide docur documenting non-adherence);		orth of pharm	nacy claims	for aripiprazole	
a) Utilization of a pill boxb) Utilization of a reminder dec) Involving family members	ring strategies to improve patient adher evice (e.g., alarm, application, or text for friends to assist se with dosing of another daily medica	reminder)	oeen tried w	ithout success:	
6) Documentation of a trial and intolerance to a preferred long-acting aripiprazole injectable agent; and					
care providers and transition m MyCite. Initial approvals will be based portal and document ad must document a plan to impro generic aripiprazole tablets mu compliance has not been estat	document adherence of Abilify MyCite nember to generic aripiprazole tablets a given for one month. Prescriber must herence for additional consideration. If we adherence. If adherence is improvest be considered. Note, the ability of tolished. If the distribution of	after a maxin t review mem f non-adhere ed, considera he Abilify My	num of 4 monber adherent ence continutation to swit	onths use of Abilify nce in the web- les, prescriber ch member to	
9) A once per lifetime approval wi	Il be allowed.				
The required trials may be overric medically contraindicated.	lden when documented evidence is p	rovided that ι	use of these	agents would be	
Non-Preferred					
☐ Abilify MyCite					
Strength	Dosage Instructions	Qua	ntity	Days Supply	

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Request for Prior Authorization Aripiprazole Tablets with Sensor (Abilify MyCite) (Continued)

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Is patient adherence to generic aripiprazole tablets less than 80% v Yes (provide previous 6 months of pharmacy claims documenting no	<u> </u>			
Have the following strategies to improve patient adherence been tr	ed without success?			
Utilization of pill box				
Utilization of a reminder device (e.g., alarm, application, or text reminder Yes Device used:				
Involving family members or friends to assist				
Coordinating timing of dose with dosing of another daily medication	☐ Yes ☐ No			
Does patient reside in a long-term care facility? ☐ Yes ☐ No				
Prescriber agrees to track and document adherence of Abilify MyCite through the web-based portal for health care providers and transition member to generic aripiprazole tablets after a maximum of 4 months use of Abilify MyCite? Yes No				
Preferred long-acting aripiprazole injectable trial:				
Drug name and dose:				
Trial dates: Failure reason:				
Medical or contraindication reason to override trial requirements:				
Renewals: Prescriber has reviewed member adherence of Abilify MyCite throu Yes Adherence rate:	<u> </u>			
If improved member adherence, consider switch to generic aripiprazole tablets. Provider rationale for continued Abilify MyCite use if not switching to generic aripiprazole tablets:				
If member continues to be non-adherent, document plan to improve adh	erence:			
Prescriber signature (Must match prescriber listed above.)	Date of submission			

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

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